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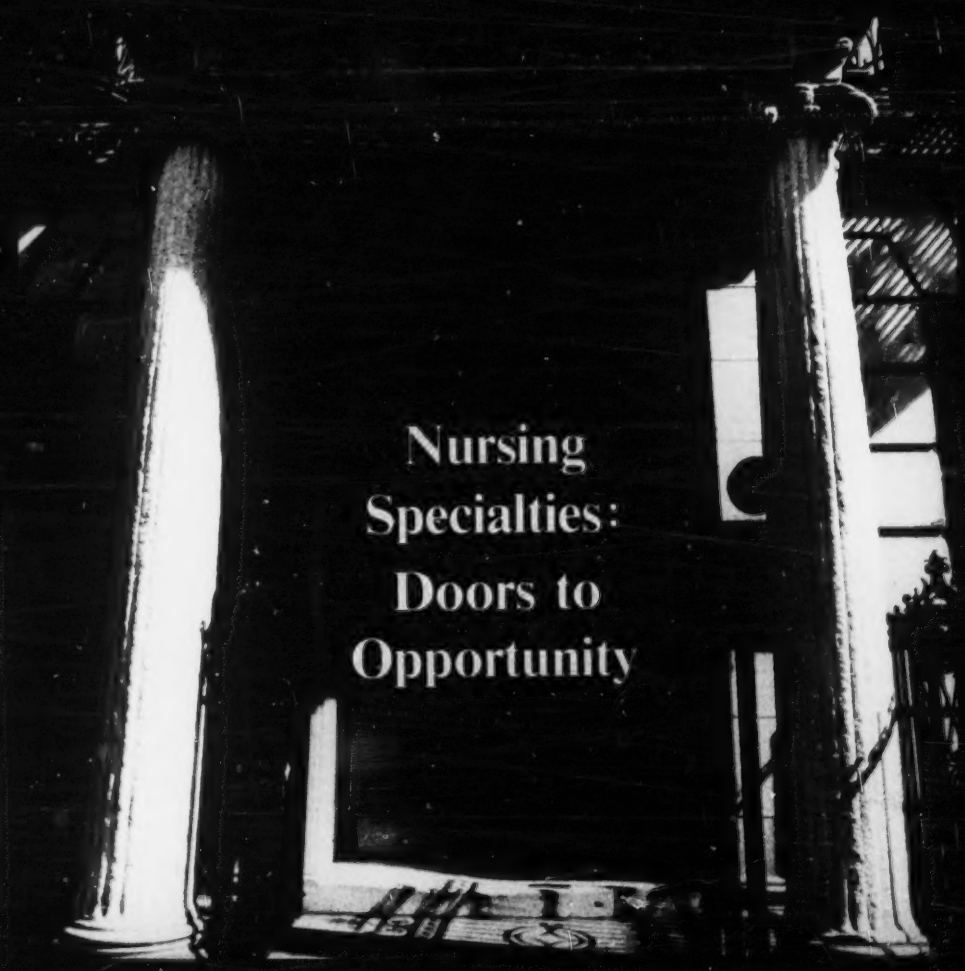

Nursing Specialties: Doors to Opportunity

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An Entrepreneurial Role for the Nurse Consultant

Sr. Mary Jean Flaherty and Dorothy DeMoya

Not all nursing specialties arise from clinical practice. Some specialties arise from the so-called functional roles. Here Flaherty and De Moya examine the nurse consultant as specialist. Furthermore, that specialty practice is looked on as an entrepreneurial role: a specialty within a specialty.

This article proposes an argument for the development of clinical specialists as external consultants. Rotkovitch (1976) proposes that the advanced preparation and skill of clinical specialists enables them to make a powerful impact on the health needs of society. Lange (1987) asserts that there is an increasing need for nurse consultants because of the technological explosion and the rapid realignment of health services in a cost-conscious society. Specialists operating within the confines of specific agencies can externalize their practices. Educators, administrators and clinical specialists can engage themselves part-time in consultative roles. In the new health care system, clinical specialists can direct care of acutely ill patients in their homes and extended care settings, design programs to prevent illnesses in schools and the workplace, enhance professional practice in multidisciplinary settings and manage complex care systems.

The historical self-image of nurses emerges as a major issue in any discussion of entrepreneurial activities. Most nurses, working in institutions, have not perceived themselves as independent practitioners with clinical skills, knowledge, and organizational ability. The unpredictable world of the entrepreneur may be an uncomfortable workplace, and role expansion may not be easy for nurses who are more familiar with bureaucratic models and defined boundaries. The impression that a transition into the competitive health world will be difficult is reinforced by a recent review of the literature.

The survey of nurse consultants

Nurses contemplating a new or expanded role as an external consultant need market-oriented information. Recently 459 consultants were asked to participate in a national survey and share their understanding, practices and beliefs about consultation.

The idea of studying nurse consultants developed during an analysis of consultation models. The survey method was selected as a strategy to elicit responses from a representative pool of nurse consultants about useful models of consultation, beliefs about consultation, and the ethical issues surrounding practice. The survey tool, developed by the investigator in consultation with a tool-development expert, was organized into four sections: Aspects of Practice, Theoretical Considerations, Ethical Considerations, and Beliefs about Consultation. Demographic data were also collected at the time of the survey.

Sr. Mary Jean Flaherty, PhD, RN, is an associate professor at The Catholic University of America School of Nursing Washington, DC and Dorothy DeMoya, RN, DNSc, is adjunct assistant professor at The Catholic University. Partial support: The Dean's Research Grant, The Catholic University of America School of Nursing, Washington, DC; 1985, 1986. The author acknowledges the contributions of Mary Terhaar, DNSc, who worked as a research assistant on this project.

A pilot instrument was sent to 50 nurse consultants randomly selected from the Journal of Nursing Administration's (JONA) Semiannual Directory of Consultants to Nursing Administration (1985). The Directory lists the following criteria to describe their roster of consultants: (a) evidence of suitable educational preparation; (b) freedom to enter consulting agreements; and (c) a fee schedule. The Directory was chosen because it represents a national listing of nurse consultants and consulting agencies that employ nurses. Forty-eight valid surveys were returned. The survey instrument was revised to address the comments of the respondents. Because the pilot group expressed overwhelming interest in the survey, the revised tool was sent to 459 consultants listed in the Directory. Four weeks later, follow-up postcard reminders were sent. Two hundred and seventy valid and 15 invalid survey tools were received for a return rate of 62%. Surveys were classed as invalid if respondents were non-nurses (N = 6) or if the forms were not completed (N = 9). Three nurses who returned uncompleted forms said that they no longer practiced as consultants, but kept the listing for tax purposes.

"The most notable finding in the demographic analysis, however, was the source of their consultation contracts: Nurses refer clients to nurse consultants."

The consultants: Demographic variables

The sample represented 252 female and 18 male nurse consultants. Their ages ranged from 28 to 71 years with a mean of 43.6 years and a median of 42 years. Family status and educational history are presented in Table 1.

On average, 9 years had elapsed since the respondents completed their formal educations. Four respondents reported graduate degrees with a major in consultation; 103 had earned credits in consultation; and 23 indicated they had taken a course in consultation in nondegree educational programs. Eighty-four percent (N = 226) listed reading as the major type of informal preparation. More than half of the respondents had formal preparation for their roles and only 11 subjects had workshop experiences.

Aspects of consultation practice

Respondents described the organization of their consultation practices. Although 63% (N = 168) of the respondents were in independent practices, only 17% (N = 45) of this group were in incorporated practices. Of those who worked in business organizations (N = 102), 52% worked in incorporated firms and 21% in partnerships. The remainder of the sample was employed in nonincorporated consulting firms. Thirty-two percent of those working in incorporated firms or partnerships were officers. Fifty-three percent of the consultants worked part-time (N = 142); 31% (N = 83) were full time consultants; 26% (N = 45) did not report their work status. Part-time consultants worked from 1 to 120 hours per week with a mean of 28 hours. Part-time consultants listed their primary employment as nursing education (24%), nursing administration (22%), and other (54%). Interestingly, clinical specialization was not identified in the broad ranging "other" category. Consultants were in practice from 1 to 30 years with a mean of 6.9 years. Fifty-six percent of the respondents decided to enter practice on their own. The remainder were encouraged by colleagues, other consultants, and family members.

Work contracts were initiated through professional relationships with other nurses (44%), non-nurses (14%), social functions (10%), presentations at professional meetings (7%), and other sources (15%). Advertisements, attendance at professional meetings, writing for professional journals, and committee work—frequently thought to provide good contacts—accounted for only 10% of the contracts (see Table 2).

Twenty-four percent (N = 66) of the consultants charged less than $50 per hour and 49% ($N$ = 133) set daily fees at $500 or less. Nine persons reported daily fees that ranged between $1,000 and $4,000. Yearly earnings from consultative practice ranged from $500 to $70,000 (see Table 3).

The profile of the responding consultants presents a cadre of midcareer professionals whose independent consultation businesses enhance and supplement their primary work and incomes. The most notable finding in the demographic analysis, however, was the source of their consultation contracts: Nurses refer clients to nurse consultants.

Financial aspects of practice were mentioned frequently in the commentaries. Respondents indicated that hospital administrators hesitated to purchase consultation services that would save them money in the future. Consultation appeared to be low on budget priority lists. In addition,

"Nurse consultants agree about the importance of fulfilling contracts and satisfying clients' interests. The high agreement by the respondents to contractual and client obligation affirms a sense of loyalty and responsibility."

nurse consultants commanded lower fees than consultants from other disciplines. The financial struggle of getting started and maintaining a consultative practice was frequently noted. The marketing of services was reported to be the most difficult task. The continuing struggles to establish practices led to frustration and an expressed need for "a network of nurse consultants throughout the country who are not afraid of losing 'turf.' "

Other issues identified by the respondents were related to preparation for consultation, opportunities for continuing education, and standards of practice. The need for educational opportunities was best described by a respondent who wrote that "post-graduate courses in consulting techniques would have saved much trial and error and 80 hour weeks to complete projects."

In many instances the respondents emphasized their professional concerns by personal anecdotes about early experiences and difficulties. One respondent found it difficult to obtain information about consultation in nursing. She rejected business information about how to get started because it was male-oriented and not applicable to her aspirations. She also reported that it took her 2 years to achieve some financial benefit from her practice.

Sixty-two percent of the respondents reported they used consultation models in their practices. This somewhat surprising finding may be explained by the data presented earlier in this paper on the number of consultants who formally studied the consultation process (N = 123). Eight consultants commented that theoretical models were not helpful.

Ethical considerations

Respondents were asked to select and rationalize their answers about contract negotiation and fulfillment. They were asked the following questions: What would you do if costs were exceeding the contract fee? What would you do if costs were running below the contract fee? What would you do if you found yourself in a situation inconsistent with your personal beliefs? What would you do if the consultee was not responding to your efforts? The responses are summarized in Table 4.

The respondents were in agreement about what they would do when costs exceeded contract specifications (44% would absorb costs). In situations where consultees were not responding to the consultants' efforts, 49% said they would try to change the situation. There was less agreement when the actual contract costs were significantly lower than negotiated fees and where the emergent situations were inconsistent with the consultants' beliefs.

"...a market needs to be created and nurses need to position themselves to provide these services. Consultation is one way of accomplishing this goal."

Professional codes appeared to guide consultants in their ethical decision making. In three of the four hypothetical cases presented, respondents selected professional codes as the rationale for their choices. There was little agreement in the reasoning about the choice of behaviors when the costs of the contract were less than those projected.

It was anticipated that the ethical issues presented in the survey would stimulate comments. For the most part, however, respondents were brief in discussing their business ethics. Perhaps the lack of response should have been expected. There is little in the literature on ethics in consultation. Gallesich (1982), one of the few to discuss this topic, makes a strong argument for the development of a code of ethics in consultation. However, in reviewing the current codes or rules of behavior that were available from five professional organizations, Gallesich (1982) found a remarkable lack of uniformity among them. It appears that the codes were designed to protect consultants from each other rather than to safeguard clients.

Beliefs about consultation

The final section of the survey evoked responses about six belief statements about consultation. The responses ranged on a five-point scale from "strongly agree" to "strongly disagree." The statements and responses are presented in Table 5.

Nurse consultants agree about the importance of fulfilling contracts and satisfying clients' interests. The high agreement by the respondents to contractual and client obligation affirms a sense of loyalty and responsibility.

Seventy percent of the respondents did not believe that nurse consultants charged enough for their services. This observation may reflect diminished self-image or the relative novelty of entrepreneurial practice. It may also explain some of the ethical dilemmas revealed in the consultants' responses to questions about over- or undercharging in contract negotiation. This finding also confirms the writer's experience that new consultants find it difficult to set fees that are appropriate, just, and competitive. One of the respondents explained that:

> One of the biggest problems has been in expanding my marketing skills. Having been trained and working as a nurse in a traditional setting for 17+ years this was and continues to be my #1 problem and concern. Consultation takes a different mind set and skills from what I'd been taught. How does a nurse who has been told she's worth $10 an hour for many years feel justified in charging $50+ an hour.

The ability to place monetary worth on work as an independent practitioner requires a positive sense of self and a belief that clinical knowledge and skills are valuable in today's health marketplace.

Discussion

Data from this survey support Gallesich's (1982) position that for-

mal education and degree preparation for consultants is important. Gallesich's (1982) educational program provides the business base needed to manage consultation practices and requires a 2-year internship. However, it may be a while before the curriculum envisioned by Gallesich becomes normative in schools of nursing. Courses in marketing, financial management, business law and the experience of working in nurse-run businesses have not characterized requirements for nursing degrees. In the interim, many consultants expressed a need for a link between consultants in order to update their knowledge and skills and offset the professional isolation of independent practice. The development of a strong consultation network would also provide a valuable resource for budding consultants. The current network, the Nurse Consultants' Association, has a membership of over 150. However, members must demonstrate that 60% of their current in-

Table 1. *Family status and education history*

Marital status	N	(%)
Married	179	67
Widowed	6	2
Divorced	38	14
Separated	5	1
Never married	42	16
Children		
None	127	48
Under 18 yr	143	52
Basic education*		
Associate	15	6
Diploma	109	42
Baccalaureate	136	52
Highest degree*		
Associate	4	2
Baccalaureate	21	8
Master's	161	62
Doctorate	74	28

* Ten subjects did not identify education.

Table 2. *Fee structure for hourly and per diem rates*

Hourly Fee ($)	N	(%)	**Daily Fee ($)**	N	(%)
Less than 35.00	24	8	100–249.99	24	9
35.00–49.99	42	15	250–499.99	109	41
50.00–74.99	90	37	500–749.99	60	22
75.00–99.99	29	11	750–999.99	16	6
100.00–124.99	25	9	1,000–1,999.99	8	3
125.00–150.00	10	3	2,000–3,999.99	1	0
Other	32	11	Other	25	9
No Response	18	6	No Response	27	10

Table 3. *Total yearly income for consultation*

Range ($)	N	(%)
500–999	21	8
1,000–4,999	47	17
5,000–9,999	35	13
10,000–19,999	33	12
20,000–29,999	20	7
30,000–39,999	34	13
40,000–49,999	12	4
50,000–59,999	11	4
60,000–69,999	6	2
Income not reported	51	19

come or 60% of their employment time is related to consultation efforts (Profiles, 1985). This criterion excludes most part-time consultants. It also disenfranchises most neophyte consultants, the group that needs the most support.

Data reported in this article have relevance for clinical specialists interested in scanning the environment before reorienting their careers. Before any such reorientation, clinical specialists must ask the following questions:

- Do I have the desire to be a consultant?
- What kind of preparation do I need?
- What kind of practice suits me and my family?
- Can I manage additional commitments and responsibilities?
- What kind of fees do I set?
- How do I get started?
- Would I like to practice on a full- or part-time basis?
- If part-time, can I negotiate a change of hours and responsibilities in my current position?
- Will my moving into this entrepreneurial world advance and improve professional nursing care?

Clinical specialists have a wealth of knowledge and experience and have the potential to improve the welfare of patients and their families, but before this can happen a market needs to be created and nurses need to position themselves to provide these services. Consultation is one way of accomplishing this goal.

Table 4. *Ethical problems in consultation*

Behavioral Response	Costs Exceeding Contract (%)	Costs Under Contract (%)	Situation Inconsistent with Beliefs (%)	Consultee Not Responding (%)
Absorb the cost	44			
Negotiate Higher fee	5			
Negotiate decreased work	2			
Negotiate fee and expected work	16	11		
Revise work output and say nothing	1			
Other solution	10	10	17	18
Do nothing		29		
Negotiate lower fee		6		
Negotiate increased work		6		
Withdraw from contract			16	10
Change situation			31	49
Accept situation			9	7
No response	22	38	27	16
Reason for Response				
Professional	67	23	43	62
Moral	17	12	19	5
Practical	8	10	4	9
Financial	6	10	1	2
Other	2	45	33	22

Table 5. *Belief statements about consultation in nursing*

Nurse consultants are:	Agree (%)	Uncertain (%)	Disagree (%)
Concerned about serving the needs of clients	93	3	4
Concerned about fulfilling contracts with clients	92	6	2
Generally prepared for the work they do	64	17	19
Respected for their contribution to development and advancement of nursing by other nurses	49	22	29
Perceived by other nurses to be too concerned with money	29	28	43
Generally charge enough for their services when compared with other consultants	14	16	70

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